Communication for Routine Immunization and Polio Eradication: A synopsis of five sub-Saharan country case studies

June 2000

Contents

Acknowledgements

This report is the result of a collaborative effort among partners: Ministries of Health, WHO, UNICEF and USAID through its subcontractors BASICS and CHANGE. Funding for this project was generously provided by USAID. We thank all those who contributed to this report for their time and effort.

Abbreviations

AFP	Acute Flaccid Paralysis
BASICS	Basic Support for Institutionalizing Child Survival
BCG	Bacille de Calmette et Guérin (anti-tuberculosis vaccine)
CHANGE	The Communication for Behaviour Change project
DPT	Diphtheria, Pertussis and Tetanus
EPI	Expanded Programme on Immunization
ICC	Interagency Co-ordination Committee
IEC	information, education and communication
IPC	Inter-personal Communication
JHU-PCS	Johns Hopkins University-Program for Child Survival
KAPB	Knowledge, Attitudes, Practices and Behaviours
MOH	Ministry of Health
NGO	Non-governmental Organisation
NHC	Neighbourhood Health Committee
OPV	Oral Polio Vaccine
PE	Polio Eradication
NIDs	National Immunization Days
SMCs	Social Mobilisation Committees
SNIDs	Sub-National Immunization Days
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

In October and November 1999, a series of case studies were carried out in five sub-Saharan countries. The broad objectives were to: a) document communication activities for polio eradication, routine immunization and surveillance; b) exchange effective and innovative experiences; and c) provide recommendations for the improvement of communication interventions. The initiative was a collaborative effort undertaken by the Ministries of Health of visited countries, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Unites States Agency for International Development (USAID) and its subcontractors (BASICS, CHANGE and JHU-PCS). Visited countries were the Democratic Republic of the Congo (DRC), Mali, Mozambique, Nigeria and Zambia.

This paper presents an analytic summary of the five country reports. An overview of communication planning and effective strategies is first given, then specific polio eradication issues are analysed from the perspective of the five studies. Finally, the main recommendations from the studies are presented.

Basic methodology

The case studies were conducted by inter-agency teams of four to five persons in each country over a period of 10 to 15 days. In general, teams visited the capital and two provinces. Visited provinces were to include one with high National Immunization Days (NIDs) coverage and another with low NIDs coverage. Within each province, the teams visited two districts, again one with high NIDs coverage and another with low coverage. Data collection involved primarily document review, semi-structured interviews among key informants and observations.

Findings

1-Polio National Immunization Days

All studied countries started polio NIDs in 1996/97, except DRC, where NIDs were first implemented in 1999 after Days of Tranquillity negotiated by the United Nations (UN). Before 1999, Sub-National Immunization Days (SNIDs) were conducted in only 5 out of the 11 provinces of DRC.

1.1 NIDs coverage

Official NIDs coverage for polio in visited countries has improved each year since the introduction of the campaigns. For example, coverage for NIDs (target: 0 to 59 months children) started with a low 47 per cent during the first round in Nigeria, to reach up to 108 per cent in 1998. In 1999, with the exception of DRC, all visited countries had a reported average national NIDs coverage above 95 per cent. However, with over 8 million children vaccinated, NIDs coverage in DRC was still considered a major success given the country's conflict situation.

Nevertheless, there were some concerns about the ability of the data to reflect the actual national NIDs coverage. Reported causes of possible unreliability were: the frequent or continuous populations movements, particularly in borders areas; the unreliable census data used to estimate the target population; and counting immunized children outside of the target population (i.e.

children above 59 months of age) in the numerator but not denominator. These three causes were shared by at least two of the five visited countries.

An illustration of the uncertainty in coverage data is the Zambian example, where results from all four years' NIDs show some discrepancies between the national Central Statistics Office and the district health count.

1.2 Linking NIDs to other health issues

The antigen administered during the first years of NIDs in four of the five countries was limited to oral polio vaccine (OPV). Later on, countries started to include vitamin A supplementation. Also, in 1999, measles vaccine was added in selected high-risk areas such as urban districts in DRC, Mozambique, Zambia and in the Kidal northern region in Mali.

2 – Integration of Polio Eradication and RoutineEPI

In visited countries, the integration of the expanded programme on immunization (EPI) with polio eradication activities needs to be strengthened. For example, few polio communication materials also promoted routine immunization. In addition, there is a major contrast between the energy and publicity as well as commitment and resources, concentrated on NIDs versus those for EPI. Not surprisingly, EPI coverage in the countries visited is reportedly stagnating or falling.

Reported constraints for optimal EPI services fall into three major categories:

1) *Lack of resources:* Limited resources, such as insufficient funds for gasoline and per diems and vaccine shortages, were identified as a constraint in Mali, Mozambique and Zambia. Staff shortage at all levels was reported in Zambia. Equipment (syringes and needles) was unavailable in Mozambique and Nigeria. In Zambia, the cold chain was inadequate and vehicles for outreach services were lacking.

2) *Poor management:* Overly centralized management (DRC and Mali), the centralization of vaccine storage leading to poor distribution (Nigeria) and the lack of leadership in the EPI programme at all levels (Mali) were reported as management constraints.

3) *Quality of services:* A scarcity of trained health workers (Mali, Mozambique and Zambia) and unmotivated health providers (Mali) were reported as important factors contributing to the poor quality of services. On top of these were the competing priorities for health workers' time identified, for instance, in Zambia.

Finally, a cross-cutting issue among the three categories above was the insufficient communication support for EPI activities. EPI communication activities were mostly limited to the health talks held at the health facilities and/or to posters, and very little outreach services were found. However, a positive point is that most countries visited were designing/finalizing (Mali, Mozambique) or starting to implement their strategic communication plan for routine EPI (Nigeria). It is hoped that this will result in improvement in communication for routine EPI activities.

3- Surveillance of acute flaccid paralysis

Some countries, such as Zambia, have made good progress with surveillance. In Zambia, although health staff training still needs to be expanded, search for acute flaccid paralysis (AFP) is now more active and data management and timeliness have improved. Most surveillance activities in visited countries, however, are confined to the health system, and very limited strategies and activities in support of community involvement in surveillance were identified. Exceptions include the community-based surveillance pilot projects in Mali and the integrated approach to transmissible diseases control in six provinces in DRC.

4 - Mop-up

As the eradication goal approaches, more SNIDs are conducted, particularly in high-risk areas such as districts that share borders with high-endemic countries. For instance, Zambia conducted SNIDs in districts bordering with Angola and DRC. In 1999, house-to-house SNIDs were particularly successful in Nigeria, one of the main sub-Saharan reservoirs of wild polio virus.

5 - Communication for polio eradication

5.1 Planning and implementing communication for polio eradication

The Interagency Coordinating Committee (ICC)

The ICCs, which include national and international organizations and donors who support immunization activities, have emerged as a strong force in support of polio eradication. In 1998, about 90 per cent of the 36 countries in the Africa region that had conducted NIDs had used an ICC to varying degrees to support the initiative. ICCs offer an invaluable and critical means of coordinating resources and technical and logistical assistance within the country. However, their role and effectiveness varies from one country to another and across different levels within each country.

At the national level

All countries visited had a national steering committee for polio eradication, usually also called the Interagency Coordinating Committee (ICC). ICC membership is often intersectoral. A good and successful example is the ICC in Mali, which includes members from different ministries, the army, the educational sector, the media and religious bodies, in addition to the agriculture private sector.

Within each ICC, there is usually a sub-group responsible for social mobilization/communication. As in the case of ICCs, their membership is generally also inter-sectoral. The way the ICC was organized in Mozambique, however, was a bit different in the sense that the core social mobilization task force was composed only of health-related agencies, but support from all sectors was later requested from the Ministry of Health (MOH).

At lower levels

In general, ICCs were to be replicated at provincial and district levels. However, while the national ICCs in the countries visited were evidently very active for polio eradication, particularly NIDs, it was often unclear to what extent lower-level ICCs were engaged and functional, particularly given the lack of accountability.

Tasks

ICCs often work on NIDs planning, coordination and management, including social mobilization, whereas the Social Mobilization Committees (SMCs) are expected to create awareness, generate demand, build support at all levels and mobilize community participation. Generally, clear instructions regarding the campaign went from national sub-committees down to the community level through lower-level committees. At national level, meetings seemed to be held regularly with a higher meeting frequency (e.g. every week) as the NIDs dates approached. However, it is important to note that as soon as NIDs were over, the Social Mobilization Committee became inactive, as it did in DRC and Zambia.

Effective ICCs:

The reported benefit of an active ICC was the strong partnership among organizations created by the joint work toward a common goal.

The studies have also found that national ICCs seem more effective when:

- they have strong and high level leadership;
- they are intersectoral;
- they have clear terms of references and mandate; and
- they meet on a regular basis.

Integrated communication plans

Integrated communication plans are a recent development. In Zambia and Nigeria, integrated communication plans were developed in 1999. The Nigerian plan is comprehensive and includes advocacy, social mobilization and programme communication strategies and activities to be completed at the national, state and lower levels. DRC has surveillance, EPI and NIDs in separate but somewhat coordinated plans that include the three communication strategies.

Research-based plans

In most of the visited countries, it is unclear how well the planning that occurs at the central and district levels has adequately incorporated the recommendations made from previous programme reviews. Also, adequate demographic and knowledge, attitudes, practices and behaviours (KAPB) data on the low-coverage populations are missing, or if they exist, they seem not to be disseminated or utilized by partners nor incorporated into the communication strategy and action plan.

Strategic planning and implementation:

In the countries visited, there is generally limited strategic communication planning. Regional differences and the characteristics of the audiences such as behaviours and their determinants, gender, educational level, local languages, etc. are seldom taken into account.

However, a mix of communication channels is used and channels include interpersonal communication, mass and traditional media. The use of traditional entertainment is also common, particularly in semi-rural areas, with dances, drama and songs.

Decentralization of communication planning:

In the countries visited, there is a general trend towards decentralization of polio eradication planning (e.g. micro-planning at provincial and district levels). In terms of communication activities, this occurs with a varying degree of effectiveness.

For example, the production of communication materials is often conducted at the central level with distribution at lower levels. This includes, for instance, the production of banners, stickers, posters and t-shirts in Nigeria and Mali. While the major advantage of this approach is the consistency of messages, the problems identified with high centralization are: 1) the fact that materials are not adapted to the needs and particular characteristics of local populations; 2) the late material distribution; and 3) the non distribution of the materials.

Provincial and district levels can plan and produce their own materials. In Zambia, for instance, some districts produce yearly action plans for all activities. Visited districts had such plans and each included a section on EPI and surveillance that includes health promotion material production. Thus, many of the materials were produced in local languages. In Mozambique, local media were utilized and the channels used were determined locally. Although communication strategies and activities are more adapted to the target audiences with this approach, there is the risk of message inconsistency, as found in Zambia. Clear guidelines for message development are thus needed. However, implementing communication activities at lower levels was reported to be hindered by late arrival of funds, which allowed little time for planning and preparations. Another reported problem was the insufficiency of funds received compared to the requested budget.

Through a combination of decentralized planning and centralized production, provincial and district levels can, however, adapt materials produced at national level. For example, in Nigeria – and in Mali for radio – although TV and radio spots were standardized, some states also made their own productions in local languages, utilizing and adapting the same information produced at the national level.

In general, it seems that a combination of a national umbrella strategy that provides basic technical content and message consistency and local level adaptation and planning is a viable approach. It is emphasized, however, that clear guidelines as well as sufficient funds need to be provided to lower levels in a timely and consistent manner to allow for material adaptation.

Communication for surveillance

Communication for surveillance, either targeting health workers and influential leaders or targeting communities, seems to have received little support. The integration of communication

for surveillance into the overall polio eradication plan needs to be strengthened at all levels and in all three communication strategies, namely advocacy, social mobilization and programme communication.

Current community-based activities include community-based surveillance pilot projects in Mali and the integrated approach of transmissible diseases control in DRC, which uses interpersonal communication (IPC) and media. In this latter case, communication audiences were limited to clinicians and community leaders. In addition to being expanded geographically, communication for community-based surveillance needs more research/evaluation, definite strengthening, expansion and scaling-up.

5.2 Monitoring and evaluation of communication for polio eradication

Monitoring polio eradication communication activities seems to vary across the countries visited. In general, however, this area needs to be strengthened, and there is a need to measure the impact of messages on audience knowledge, attitudes and particularly behaviour. Results should be used as an assessment and motivation tool to stimulate communication activities towards improving immunization coverage.

In Nigeria**,** monitoring of NIDs through the supervisory checklist on social mobilization is reported to be implemented at all levels. Forms are also used to monitor the distribution and utilization of the materials. Media plans implementation are monitored only in a few states, due to lack of funds. In Zambia, the inability of the NIDs Secretariat to conduct physical checks on actual implementation at district level was reported. However, some evaluation happened during the NIDs review meetings held with districts. Supervision was only implemented in some provinces in DRC and was therefore not consistent.

5.3 Effective and innovative strategies

Advocacy :

Polio eradication advocacy at the national level seems to have been a success in all visited countries. International-level advocacy through the United Nations and the Organization of African Unity was particularly successful in obtaining the Days of Tranquillity in DRC. High-level and multi-sectoral partners were mobilized in all countries. Heads of States and their wives personally launched NIDs in DRC, Mali and Mozambique.

Advocacy was generally achieved through a cascading approach that started at the head of state level down to lower levels. With few exceptions, national-level advocacy was achieved mainly through meetings/briefings and letters. An illustration of this successful advocacy is the decision in DRC to stop commercial activities during National Immunization Days to allow mothers to immunize their children.

Interpersonal communication channels:

There are more and less appropriate channels to mobilize and educate different populations, which is one reason for using a mix of channels in polio eradication.

However, according to interviews from the case studies, it seems that interpersonal communication, particularly through town criers, community leaders and women's organizations, was very effective in mobilizing rural and semi-rural population. IPC remains the most culturally and linguistically appropriate channel. IPC is also found to be the most effective channel used in scattered rural areas, with poor and illiterate populations without access to mass media, as in Mozambique. In this latter case it was found that community leaders were ready to walk several hours to reach remote families in their area of responsibility. In Mali, mobilization was obtained through word of mouth, door-to-door visits and communication through traditional community networks.

In Nigeria, however, findings vary between states and more research is needed to ascertain which channel is the most effective in which region. In fact, a survey conducted in October and December 1999 with respondents from the 36 states found that radio jingles were the source of information for 56 per cent of the respondents. Only a negligible proportion in this study mentioned the town criers. However, results from a WHO-led evaluation of social mobilization activities during the 1999 SNIDs found that IPC, particularly through local traditional and religious leaders, neighbours and criers was more effective in reaching the population than posters and other print media.

In all five countries, there is great evidence that oral communication (either through radio, town criers, leaders or women's organizations) is one of the most effective way of reaching and mobilizing the population for polio eradication. This confirms the already well-known strength of *Oralité* in sub-Saharan African culture.

Clear guidelines:

Clear guidelines and instructions to communicators as well as specific suggestions for activities and tasks at the various levels were reported as a major factor in successful NIDs. In Zambia, additional guidelines on how to deal with rumours and with the media are innovations that could be shared with other countries. The rumours guide seems to have been particularly useful at community level.

Community ownership:

Although not found in all visited countries, community ownership was emphasized as having played an important role in successful NIDs in Zambia. The Neighbourhood Health Committee (NHC), composed of community members, contributed actively in the development of each district plan.

Accountability and sense of competition:

In Mozambique, the personal accountability of provincial governors for the success of NIDs increased their personal involvement and triggered a positive sense of competition.

Strong partnership with the media:

The experiences of the countries studied demonstrate the power of a strong partnership with the media in rallying different partners and mobilizing the society on a particular health issue.

In Mozambique, this partnership was illustrated by several activities that include: a) training of journalists in EPI; b) payment of journalists' expenses; c) the greater availability of MOH officials to the media; d) existence of a MOH media-liaison person who worked from the deputy minister's office; e) weekly press conferences for all media from the deputy minister; and f) award of a best health journalist prize from WHO. As a result, media played a major role in advocacy and social mobilization for NIDs. In DRC, international media seem to have been a pillar of the NIDs. In Mali, although not always strategically the best media for reaching women in some provinces visited, a well developed network of community radios played a preponderant role, particularly for mobilizing hard-to-reach populations such as the nomadic groups in Kidal**.**

Leadership and role of public personalities:

Identifying an effective leader who can influence decision makers and lobby effectively for resources and support is key. In Mozambique, public personalities like polio survivor Farida Gulamo helped create and sustain interest in the NID.

Children's involvement:

In addition to being an effective way of community involvement, youth participation is a long-term investment in influencing and educating tomorrow's parents on health. According to their age, youth can play different roles in polio eradication. Scheduling NIDs according to when children can be most easily accessed, as reported in Zambia, is a way to show how important youth participation is. In Zambia, school pupils were reported as having played an important role in NIDs. In fact, while primary school-level pupils were effective in social mobilization, the older high school student served as volunteers at immunization posts. In Mali, a creative initiative involved children in designing and producing an educational radio broadcasting on polio. DRC also used children for peer education.

The Zambian EPI communication model:

Zambia is recognized throughout Africa for its sustained high level of immunization coverage. However, is it interesting to note the discrepancy between the lack of staff and resources and the relatively high level of routine immunization coverage (78 per cent for all antigens). Although this observation merits additional research for possible positive lessons to be shared with other countries, the following points can be emphasized:

- Other sectors (schools and religious organizations) supported the health system in providing health education on immunization.
- Rules or laws were used to reinforce behaviour change.
- The existence of an institutionalized, single symbol of immunization, easily recognized by the population: the immunization card.

Financing immunization:

Adequate and sustained funds availability remains a must for the successful implementation of polio/EPI, including communication, advocacy and social mobilization. There is a need to provide a supportive environment for the establishment of creative initiatives such as the Nigeria Immunization Funds.

Created in 1999, the Nigeria Immunization Funds appeals to the private sector to finance immunization. Since it is still at its initial stage, this initiative needs to be followed up for effectiveness and sustainability and to ensure that communication for immunization activities are included in action plans.

In Zambia, health reforms began in 1992, and recently an innovative financing procedure of 'basket' funding was created. The procedure requires that donor funds be given centrally through the Central Board of Health (CBOH) rather than directly supporting particular districts or provinces. The CBOH then allocates funds, leading to more efficient use of donor financing. This initiative also merits careful review for possible replication of positive lessons learned.

6 - Added value from polio eradication

6.1 Partnership

In Zambia, it was reported that implementing NIDs has tremendously helped the various partners to experience how a common goal can bring people to work together and succeed. Likewise, in Mozambique, a country that was at war until 1992, NIDs were the illustration of a successful national reconciliation process following the conflict. Polio eradication was converted from a health issue to a matter of national pride.

6.2 Strengthening skills in planning and social mobilization:

In Zambia it was reported that implementing NIDs has built confidence among stakeholders and enhanced skills in planning and social mobilization.

7 - Specific polio eradication issues

7.1 House-to-house strategies

In 1999, Nigeria became the first African country to conduct house-to-house NIDs. DRC also implemented this strategy in some provinces that year. A potential problem of a house-to-house strategy is confusion, particularly among parents of zero-dose children, that all immunization services would now be provided by house-to-house rather than through the health facility. Communication should particularly focus on clarifying these messages and addressing communication and social mobilization needs that are specific for house-to-house strategies.

7.2 Partnership and participation (national level)

In general, partnerships at the national level varied. Partnerships usually included Ministries of Education, Social Affairs, Youth, Information and Defence, and private sectors such as the large multinational companies, like British Petroleum in Mozambique. In addition to the global alliance of polio partners, religious bodies and the major international organizations and non-governmental organizations (NGOs) also contributed to the polio eradication campaign.

7.3 Partnership and participation (grass-roots level)

The participation of local political and religious leaders, mayors, women's groups and village chiefs was key to social mobilization. For instance, in Zambia, the participation of the Neighbourhood Health Committees, elected by the community, in promoting immunization made a difference to the programme since, caretakers preferred and trusted them because "they live with them." In Nigeria, several states noted the important role that Christian, Muslim and Apostolic leaders played as advocates and mobilizers in ensuring that the children in their congregations were vaccinated during NIDs. Furthermore, communities gave in-kind support such as lodging and meals for vaccinators in DRC, or boats and other means of transportation in Mali.

However, it seems that often community leaders' tasks were limited to mobilizing the population, following instructions that they received. Communities participated in a limited way in planning the NIDs activities. Exceptions include some successful initiatives such as those involving nomadic chiefs in Mali.

7.4 The hard-to-convince and the hard-to-reach

Hard-to-convince:

Identified hard-to-convince populations may include the following groups:

- religious groups
- population segments in high socio-economic strata
- poor families in urban areas.

Experiences from the case studies show that hard-to-convince populations were successfully convinced through intensified outreach with IPC and through the involvement of their leaders. In DRC, focus groups among hard-to-reach religious groups found that their attitudes were based on misconceptions and rumours that could be addressed successfully by the programme. Also, some negative attitudes were created by a bad perception of health workers by caretakers.

Although these populations were identified in each country, polio eradication planners lack a precise idea of the number of children in these groups and therefore the attention they merit. Further research would be useful.

Hard-to-reach:

Successful experiences in reaching the hard-to-reach populations were either very top-down or participatory. For instance, isolated fishermen and farmers were identified as hard-to-reach populations in DRC. Through orders from the administrative authority, they stopped their activities during three days and attended the immunization sessions.

In Mali, however, the training of the traditional chiefs of nomadic populations in Kidal made possible their active participation in logistical planning and social mobilization for the NIDs among their communities. This resulted in a doubled turn-out at the NIDs.

7. 5 Gender issues

In visited countries, the choice of channels has not fully taken gender differences into account. Communication strategies and messages should be more gender sensitive.

Although informal and formal networks of women were very effective in mobilizing their peers, in general involvement of women's groups or organizations in planning and making decisions in polio eradication activities was limited.

On the other hand, there is a growing recognition of the role that can be played by men in the well-being of children. This is illustrated by the CUP (Caring and Understanding Partners) project in Nigeria. In this project, Nigerian men, especially fathers, were targeted during football competitions in several states with messages and through various media to be "Caring and Understanding Partners" in the health and well-being of their children. This issue was also addressed in polio messages in DRC and in Mozambique through a newspaper article.

7. 6 The issue of fatigue

'NIDs fatigue' was not found to be a major issue in visited countries, although a few respondents noted the complete stoppage of other work during NIDs. Donors' NIDs fatigue was mentioned in Zambia.

7.7 Dealing with rumours

Inconsistency in messages can create contradictions as well as a favourable environment for rumours.

In Zambia, successful handling of rumours used the following community-level strategies:

- through IPC by outreach workers and door-to-door immunization;
- through written guidelines to support district-level planners;
- through one spokesperson for all EPI information. Inquiries from provincial district and health facility managers were all channelled directly to the spokesperson for any official comments; and
- through the use of community/religious leaders and other 'influence brokers'.

7. 8 Motivation of health communication workers

Different views were reported regarding the issue of health workers and volunteers' motivation and incentives.

While some volunteers were willing to work hard 'for free' during NIDs, others were said to delay the campaign until they received incentives. Medical students in Zambia, for instance, were found to be particularly enthusiastic and reliable, whereas technicians lacked motivation as there was no incentive offered in spite of increased workload.

In Mozambique, one of the keys to successful social mobilization for NIDs was the availability of per diems for health staff and volunteers. T-shirts and caps for vaccinators and traditional leaders also appeared to have been an important incentive in the campaign. Likewise, in Zambia, planners are leaning towards the use of non-financial incentives, such as recognition through the presentation of certificates to districts identifying AFP cases as a form of encouragement.

The Nigeria study recommends that there should be a system to motivate and sustain social mobilization committee members through secure salaries or stipends/per diem to support their work and transport costs.

7. 9 Linkages with EPI

Findings regarding the integration of EPI promotional messages into NIDs messages vary.

Two countries out of the five visited seem to have somewhat integrated routine EPI messages into NIDs promotion materials. In Nigeria, television and radio spots used for the NIDs campaign provided information on NIDs but also on the need to come for routine immunization services. Also, during house-to-house visits, it was reported that criers and vaccinators told people to continue to come to the facilities for immunization services. However, in Zambia, a 1998 survey found that while 85 per cent of volunteers were found to be reminding mothers to come back for regular immunization, 53 per cent of caretakers said they were not reminded about routine immunization. This result suggests confusion among caretakers about the relation of NIDs and EPI as well as a need for improving EPI messages during NIDs.

In these studies, however, differing views were expressed as to whether or not NIDs messages actually confused mothers regarding continued routine immunization. While some of the interviewees were certain about caretakers knowing the difference, others were convinced about the confusion. In Mali, for example, confusion was reported concerning:

b) the cost differences of the two services;
c) the child's vaccination status after attending one of the two services; and
d) the effectiveness of EPI vaccines.

Besides confusion among caretakers, another major negative effect of NIDs on EPI is the competition for resources. NIDs were reported to divert staff and funds from other health priorities. In Zambia, for example, it was reported that some districts were obligated to shift funds from other programmes, including EPI, in order to meet the NIDs campaign needs.

A couple of positive points, however, were reported regarding the influence of polio eradication on routine EPI. For instance, in DRC, new partnerships for EPI were created during NIDs and a 'new culture on immunization' was said to be growing.

7. 10 Communication in conflict areas

At the time of the study, although Mali and Nigeria were also experiencing geographically limited conflict/troubles, the study on communication for polio eradication in conflict areas was restricted to the case of DRC. In DRC, where major improvements in polio eradication were achieved in 1999, important factors of success were the following:

- a cease-fire obtained through combined effort of the government and international community;
- instructions given to the army to facilitate vaccine distribution and vaccinator's mobility;
- leadership of UN agencies;

- strong support from international media; and
- duplication of the central coordination structure and extra resources for occupied areas.

7.11 Cost analysis

Limited information was available on the impact of the different mass media channels. However, as discussed earlier, there seems to be a general consensus that IPC is a very effective channel in mobilizing community-level populations in visited countries. As a result, when coming to cost issues, there should be more balance between the proportion of funds allocated to the production of costly materials (TV spots, banners, stickers) that reach, mobilize and educate a minor percentage of the population versus those that not only could reach a large number of the population (radio) but that have more potential to being culturally appropriate like traditional channels and IPC.

More cost-effective communication activities could be achieved through:

- the involvement of community leaders, who know their communities;
- the timely release of funds to lower levels, to allow them to plan strategic, and therefore more cost-effective, communication activities; and
- taking into account gender differences and other major audiences characteristics when developing communication strategies and materials.

Recommendations

1-Improve the availability of reliable immunization coverage data

Reliable immunization coverage data on which to measure the success of NIDs and routine immunization were not always available in the visited countries. It was therefore difficult to measure the true coverage of NIDs or routine immunization.

In order to improve coverage data, the studies suggest a number of alternative actions:

- Adjust denominator figures to realistic levels on the provincial and/or district level for estimating coverage.
- Conduct national and/or provincial coverage surveys.
- If NIDs coverage is over 100 per cent and possible counting of children over 59 months of age has been ruled out, consider using this revised coverage figure as the denominator for future coverage.

2-Strengthen health education

Although social mobilization has been very successful in mobilizing the majority of the populations to attend the NIDs, more effort should be geared towards providing basic health education to caretakers. Such education could be an investment in the improvement of their knowledge and attitudes towards immunization. Although information is seldom enough for people to change behaviour, improved knowledge and understanding as well as supportive attitudes towards immunization by secondary audiences/influencers, could positively increase and sustain the long-term demand for EPI services.

Health education activities do not have to be costly and can be grafted onto what already exists. However, they need to be strategically designed and appropriate to their audiences. Suggested activities include:

- *Use of face-to-face communication at each immunization point*: With this perspective, vaccination teams should be trained in information, education and communication (IEC) skills and particularly interpersonal communication, to improve demand and acceptance of immunisation services by the populations. For example, a short list of three to four key points could be provided to the vaccinator and the person who checks each immunised child. The information could be provided to three or four mothers/caretakers at a time. In addition, mass media and/or traditional media could be used while mothers and children are waiting for immunizations.

- *Involve non-health professionals to provide health education*: Besides NIDs, health education should be provided routinely through a variety of channels. Channels could include schools, religious gatherings, traditional media such as drama and songs, women's groups and youth groups. In Mali, for instance, a very well developed and well-structured network of women's associations could be instrumental in adding this ingredient of education.

- *Institutionalize health education* into avenues such as school curricula and programmes conducted in health facilities. This is a way of investing in current and future basic health knowledge among the country's population.

3-Improve the integration of routine EPI and surveillance of AFP with polio eradication activities

In most of the visited countries, NIDs have benefited from a major impetus of creativity and commitment from many people. Communication activities for routine EPI and surveillance of AFP, however, have received limited support and attention. Few materials and activities on routine EPI and surveillance were developed and implemented in visited countries.

In addition to the further dissemination of the *Communication Handbook for Polio Eradication and EPI* [1] and the dissemination of good examples of integrated communication plans, the studies suggest that as much as possible NIDs health education and social mobilization materials should include promotion of EPI and surveillance. This incorporation should be systematic and should be emphasized in the national polio eradication guidelines.

4-Dedicate resources to conducting quality research

In at least four of the five countries visited, it was found that data on knowledge, attitudes and practices of the audiences are insufficient or not adequately utilized when they do exist. Yet one cannot plan strategic communication or behaviour-change activities without an in-depth understanding of these audiences.

It is emphasized that well-designed in-depth studies that answer key questions, although essential, do not have to be costly. Clearly presented findings should be incorporated into programme and communication planning. There is a need to set aside a minimum amount of funds for conducting formative, operational and qualitative research for advocacy, social mobilization and programme communication. These set-aside funds could benefit not only polio eradication but also EPI and other health issues, if the research is carefully designed. Research should be focused on identifying and defining barriers to ideal behaviours and assessing the factors that facilitate the desired behaviour. Funding and time spent in conducting formative/behavioural research will result in improved development and effectiveness of materials.

Furthermore, coordination and dissemination of existing research data should be improved. This will avoid the loss of the benefit of key information when personnel change occurs. An accessible-to-all database is needed at national level in most visited countries.

5-Develop more strategic communication interventions

Strategic planning of communication interventions needs strengthening. While a mix of channels are usually used in National Immunization Days, more strategic planning that takes into account audience characteristics such as gender differences could improve the cost-effectiveness of communication activities. Again, the necessity of research data for research-based strategic planning is emphasized.

6-Increase and sustain community participation in polio eradication and EPI

The studies have identified several successful examples of community participation that triggered creativity and solved logistical and strategic issues. For instance, local-leader involvement has

[1] The handbook can be downloaded through the Internet (http://www.unicef.org/programme/gpp/index.htm) or hard copies requested through mail (GPP/PCSM TA-24 A, 3 United Nations Plaza, New York, NY 10017).

particularly helped in successfully reaching hard-to-reach/convince populations. There is ample evidence that community participation has a potential that remains largely untapped.

Therefore, the studies indicate the benefits of early and active involvement of communities in all three polio eradication strategies, namely NIDs, EPI and surveillance of AFP. In particular, community participation in surveillance is strongly recommended since previous studies showed that only a limited portion of AFP cases are brought to health facilities. In addition, participation should be, whenever possible, in the areas of assessment, analysis and action, but not limited to passively following instructions received from higher authorities.

Within this perspective, immunization and surveillance data should be regularly fed back to community/district/provincial levels. This could be motivational and could trigger problem-solving, and create an atmosphere of friendly competition among the districts.

7-Take advantage of momentum and structures created by NIDs to improve routine EPI

As much as possible, countries should take advantage of the creativity and momentum generated by NIDs to improve EPI. For instance, the studies have suggested:

- maintaining and supporting intersectoral committees at various levels to promote immunization and other child health issues. If various committees already exist, improving coordination among those groups to prevent parallel and conflicting activities;
- devising one or two simple indicators that can also be publicly monitored and then periodically fed back to lower levels (provincial and districts). One possibility is, for example, the percentage of children who are fully immunized when they reach their first birthday. This would create a friendly competition in addition to stimulating problem analysis and action;
- incorporating EPI information/health education, on a systematic basis into polio eradication materials. Since EPI seems to be presently such a tightly funded programme, why not take advantage as much as possible of the money for polio eradication to revitalize EPI;
- immunizing children for other diseases, particularly when reaching hard-to-reach and/or zero-dose populations during NIDs. At the same time, it could be useful to provide hard-to-reach populations with a basic health education ‘package’ (an ‘educational integrated management of childhood illness’) that emphasizes immunization. Although this initiative requires significant additional planning, logistics, training and resources, the overall result could be beneficial and more cost-effective: if these populations are hard to reach during NIDs, they are very likely to be hard to reach for other health services as well.

8-Strengthen monitoring and evaluation and supervisory systems

Monitoring and evaluation of the communication components of polio eradication and EPI programmes need to be strengthened and should include indicators to assess knowledge, attitudes, practices and behaviours of both health workers and caregivers. Some of the visited countries have supervisory checklists on social mobilization. However, lists should be expanded to include specific programme communication indicators and clear guidelines for supervisors that are enforced as well.

9-Develop a culture of client-oriented health services

While caretakers may be easily mobilized to bring their children once or twice to health facilities, if services are not minimally satisfactory or if caretakers feel unwelcome or are uninformed, they

will not return for the full series of routine immunization. There is therefore a need to improve the quality of services and communication activities at immunization sites. While quality factors are not all directly communication related, the ability of health workers to communicate adequately with caretakers is vital for client-oriented health services. There is a need to establish a continuous system of training and refreshment courses on communication that emphasize IPC for health workers/lay volunteers at all levels, as well as monitoring and supportive supervision of this new culture within the health system. (In fact, the health system treating its personnel more respectfully may well be an essential step for health workers to treat clients better.) This training system should not be only ad hoc but on a continuous basis. Distance education is, for example, an area that merits exploration.

10-Institutionalize partnership with media

With the above-mentioned perspective of public monitoring and feedback at lower levels, the ongoing partnership of ministries of health and development agencies with the media (national, provincial and community level) could represent the backbone of a public-friendly feedback system. It is suggested that partnership with media be not solicited on an ad-hoc basis but be established and continuously maintained. Public health will definitely benefit from the institutionalisation of such partnership.

To this end, it is also suggested that not only media people such as journalists be trained in health issues but health professionals receive exposure to media systems as well.

11-Develop a long-term partnership with the private sector

Partnership with the private sector should be expanded and whenever possible institutionalized. A particular emphasis should be put on the involvement of private medical practitioners in polio eradication.